DECLARATION OF SHELLEY K. BUNTING

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA **DECLARATION OF SHELLEY K. BUNTING**

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

1. I am the parent and next friend of C.B., a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am the mother of C.B., a 16-year-old boy. I have also been a nurse practitioner for over 20 years.

3. C.B. is a junior in high school. Like many teenage boys, he likes hanging out with his friends, swimming, cars, and playing video games.

4. C.B. is transgender, which means he was designated "female" at birth but has a male gender identity.

5. Ever since he was a young child, C.B. would reject stereotypically female clothing and would dress in a more masculine manner. There were times he would refuse to leave the house if the outfit I had picked out for him was too feminine or would be considered "girl's clothes."

6. In late 2016, he began wearing a short, typically masculine haircut.

7. Though C.B. always got along with people and has many friends, he exhibited high levels of anxiety and depressive behaviors that concerned me as his mother. His father and I later came to understand that these behaviors were was associated with C.B.'s untreated gender dysphoria.

8. In January 2017, C.B., who was then 11 years old, called me into his room. He had something to tell me, and I could tell it was very hard for him to say it. Finally, he said, "Mama, I don't think I am supposed to be a girl." I hugged him, reassured him, and told him we would figure this out together.

9. We spent the next several months gathering information and learning what it means to be transgender.

10. Soon after C.B. shared with me who he was and how he felt, C.B., his father Michael D. Bunting, Jr., and I all met various times with a therapist in early 2017. After consultation with the therapist, C.B. asked to be placed on treatment to delay female puberty.

11. In April of 2017, C.B., Mr. Bunting, and I sought an appointment with the Duke Child and Adolescent Gender Care Clinic ("Duke"), which was ultimately scheduled for August 2017.

12. During the summer of 2017, C.B. socially transitioned to living as his true self, informing friends and family of his male gender identity, wearing more masculine clothes, and living openly as the boy he is. However, as his chest began to develop

during the summer, I recall C.B. experiencing additional anxiety. C.B. was mortified by his breast buds and we spent all summer putting band aids over them so they were not visible through his swim shirts.

13. As a result of the distress associated with his birth-designated sex, C.B. was diagnosed with gender dysphoria. In August 2017, C.B. began obtaining care from medical and mental health professionals and was prescribed puberty-delaying treatment, in the form of an implant, as part of his treatment for gender dysphoria.

14. Following the beginning of C.B.'s treatment, we noticed that the anxiety he had been experiencing diminished and that he became a more happy, outgoing, and personable teenage boy. As parent, it was such a relief to see my son begin to be truly comfortable in his own skin.

15. In fact, C.B. is treated and known as a boy at school and in all other aspects of his life. He legally changed his name to his current more typically male name in the Spring of 2018, and his passport and driver's license both reflect that he is male.

16. Because Mr. Bunting enrolled in the NCSHP as a North Carolina state employee and remains enrolled and continues to receive health care benefits as a retiree, C.B. is also enrolled in the NCSHP, as a dependent. Our family contributes a premium each month to the plan. We pay the same amount for family coverage as others, even though we receive inferior coverage because of the exclusion for gender-affirming care.

17. When C.B. came out to us in 2017, the NCSHP did not contain an exclusion for coverage of gender-confirming health care. As a result, we were fortunate

enough to have coverage for C.B.'s treatment for his gender dysphoria when we first started this journey in 2017.

18. Without coverage in 2017, it would have been much more difficult, if not impossible, for us to pay for the medical care C.B. needed at the time. Without such treatment, C.B. would have undergone a puberty inconsistent with who he is and which would have been source of a lot of anxiety and stress for him. I cannot imagine how we would have handled that as a family and how worried we would have been about C.B.'s wellbeing.

19. C.B.'s puberty-delaying implant was only meant to last 12 to 18 months. Accordingly, C.B. needed the implant to be removed and replaced in early 2019.

20. However, in mid-2018, I learned of the reinstitution of the Exclusion of coverage for gender-confirming care within the NCSHP.

21. Worried that we could not afford out-of-pocket the puberty-delaying treatment that C.B. needed, Mr. Bunting and I communicated with the NCSHP Board of Trustees, urging them to once again eliminate the Exclusion of gender-confirming health care within the NCSHP, with no success.

22. I personally testified at the NCSHP Board of Trustees meeting on October 22, 2018 and provided written testimony for the meeting on December 10, 2018.

23. Notwithstanding our pleas, the NCSHP Board of Trustees decided to keep the Exclusion of coverage for gender-confirming care in the NCSHP.

24. Figuring out how we would pay for C.B.'s gender-confirming care caused a great deal of stress and strain within our family. As parents, we want to make sure that our children get access to whatever health care they need. However, we did not have the resources to pay for a puberty-delaying implant out of pocket.

25. As we considered how we would pay for C.B.'s gender-confirming care, we contemplated several options including having my husband retire and find a new job outside of the state system, increasing my hours at work to full time, or trying to purchase a separate medical policy for my son through the Affordable Care Act Marketplace. None of these options were ideal since my husband was not ready to leave his job, I love the balance I have between family and professional life, and another policy would cost us several hundreds of dollars per month if C.B. qualified.

26. Ultimately, we needed to avail ourselves of more than one of the above options to pay for C.B.'s care.

27. In mid-December 2018, following the lack of action by the NCSHP Board of Trustees at their December 2018 meeting to eliminate the Exclusion, Mr. Bunting and I decided to purchase an additional health insurance plan that would cover puberty-delaying treatment for C.B. Through the federally-run ACA health care exchange, we purchased an additional insurance plan for C.B. from Blue Cross Blue Shield of North Carolina. A true and correct copy of the Certification of Health Insurance Coverage for this plan is attached as Exhibit A.

28. Though C.B. and Mr. Bunting remained enrolled in the NCSHP and will continue to do so, purchasing additional coverage for C.B. was necessary for my family to be able to afford C.B.'s gender-confirming care. As a result, Mr. Bunting and I had to pay an additional monthly premium of $199.57 as well as a $6,750.00 deductible for C.B., separate and apart from C.B.'s existing coverage under the NCSHP.

29. In early 2019, C.B. began obtaining puberty-delaying treatment via injection, rather than a longer-lasting implant, because that was the only puberty-delaying treatment on the formulary of the additional health insurance we purchased to supplement the coverage under the NCSHP.

30. In March 2019, C.B. was also prescribed testosterone as part of his treatment for gender dysphoria. Due to the Exclusion, the NCSHP has not covered any of this care.

31. On March 21, 2019, CVS, which administers the prescription benefits under the NCSHP, issued a Notice of Determination denying prior authorization for coverage of C.B's Testosterone Cypionate IM Injection prescription. The Notice of Determination explained that C.B. did not meet the requirements of the NCSHP. Per the Notice of Determination, the prescription would have been covered for "primary or hypogonadotropic hypogonadism," among other reasons. A true and correct copy of the Notice of Determination is attached as Exhibit B.

32. On March 25, 2019, January 17, 2020, and March 23, 2020, CVS issued additional Notices of Determination denying coverage for C.B.'s Testosterone Cypionate

IM Injection because he did not meet the requirements of the plan and the plan would cover the prescription if C.B. had "primary or hypogonadotropic hypogonadism." True and correct copies of theses Notices of Determination is attached as Exhibit C, Exhibit D, and Exhibit E, respectively.

33. Aside from having to purchase the additional coverage for C.B., the lack of coverage under the NCSHP due to the discriminatory Exclusion forced our family to make difficult decisions. Given the high deductible of $6,750.00 that was part of the additional coverage, we still needed to come up with ways in which we could increase our income in order to pay for C.B.'s necessary care. This was a significant contributing factor to Mr. Bunting's decisions to retire from his job at UNC, which allowed him to obtain a new job and increase the family's income.

34. Mr. Bunting and C.B. remain enrolled in the NCSHP as a retiree and his dependent, respectively.

35. C.B. continues to receive masculinizing hormone therapy as part of his gender-confirming care. While the family no longer purchases separate ACA coverage, C.B.'s hormone therapy is not covered by the NCSHP and we must pay for that care out-of-pocket.

36. The Exclusion discriminates against and stigmatizes C.B. as a transgender person which has impacted our family financially and emotionally, causing us to live a life of ongoing stress, anxiety, and uncertainty.

37. No child should be denied medically necessary care because of who he is. Being discriminated against does not feel good. Yet, that is what the NCSHP has done to my son and our family by refusing to cover his medically necessary health care because he is transgender. It makes me mad and sad at the same time to know that our state refuses to pay for medically necessary health care for its own state employees and their families.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: November 24, 2021

Shelley K. Bunting

Shelley K. Bunting

Subscribed and sworn before me, a Notary Public in and for the Chatham County, State of NC, this 24 day of November, 2021.

MARGARET E ASHNESS NOTARY PUBLIC CHATHAM COUNTY, NC

Margaret E Ashness

Signature of Notary

5/12/2020

Exhibit A

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

CERTIFICATION OF HEALTH INSURANCE COVERAGE

12/31/2019

Subscriber ID: [redacted]

IMPORTANT - KEEP THIS CERTIFICATE: This certificate confirms your dates of health care coverage. Our records indicate your coverage was terminated as of the DATE COVERAGE ENDS shown below due to the subscriber requesting to be terminated from the policy. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

MEMBER NAME	DATE COVERAGE BEGAN*	DATE COVERAGE ENDED
[redacted] C.B.	01/01/19	12/31/19

* "Date Coverage Began" only reflects the start date of your most recent coverage. You may have had other Blue Cross and Blue Shield of North Carolina coverage that is not reflected in this certificate.

For questions about this form, please call Customer Service at 1-888-206-4697, 8 a.m. to 7 p.m., Monday through Friday, EST. We hope to have the opportunity to provide you and your family with your health plan needs again in the future.

STATEMENT OF HIPAA PORTABILITY RIGHTS

Preexisting condition exclusions: Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan: Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

> Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor: Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged for a similarly situated individual.

Right to individual health coverage: Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Exhibit B

CVS caremark

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

Notice of Determination

Date: 03/21/2019

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B.
Plan Member ID: *******[redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-9196848225
Prescriber Fax: 1-9198625782

Dear C.B.:

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate IM Injection. The request was denied because:

You do not meet the requirements of your plan. Your plan Testosterone Products criteria covers this drug when you meet one of these conditions:
- You have primary or hypogonadotropic hypogonadism
- For testosterone enanthate injection (generic Delatestryl), you are a postmenopausal patient with metastatic breast cancer, surgery is not possible, and other drugs for your cancer did not work for you
- For testosterone enanthate injection (generic Delatestryl), you are a premenopausal patient with breast cancer, have a hormone-responsive tumor, and had your ovaries removed
- Testosterone enanthate injection (generic Delatestryl) or Testopel is being prescribed for delayed puberty

Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at 888-321-3124.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

Exhibit C

CVS caremark

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

Notice of Determination

Date: 03/25/2019

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B.
Plan Member ID: *******[redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-919-862-1200
Prescriber Fax: 1-919-862-5782

Dear C.B.:

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate IM Injection. The request was denied because:

You do not meet the requirements of your plan. Your plan covers this drug when you have primary or hypogonadotropic hypogonadism. Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at 888-321-3124.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

If your situation is urgent as defined by law, you may ask for an expedited appeal. Important information about your appeal rights and directions about how to ask for an appeal are provided with this letter.

If your provider would like to discuss this decision with a clinical reviewer at CVS Caremark , your provider can call CVS Caremark , and we will make arrangements for the conversation.

If you have questions, please call Customer Care at 888-321-3124.

Sincerely,

CVS Caremark

Enclosures

cc: Dr. [redacted]

PA# North Carolina State Health Plan 0274 Non-Grandfathered 19-038180875 SB
Plan-approved Criteria: Testosterone Products
Claim Amount (if available): 0.0
Service Date: 3/25/2019 3:28:05 PM

If your provider included diagnosis or treatment codes with your claim for Testosterone Cypionate IM Injection to CVS Caremark , that information is listed here:
ICD diagnosis code: E34.9
Associated diagnosis: Endocrine disorder, unspecified
CPT treatment code:
Associated treatment:
You may wish to contact your provider for more information about these codes.

Important Information About Your Appeal Rights

What if I need help understanding this denial? You may contact CVS Caremark by calling **1-800-294-5979** if you need assistance understanding this notice or our decision to deny you a service or coverage.

What options does my provider have? If there is relevant information that has not been previously submitted, the treating physician may request a Provider Courtesy Review (PCR) by calling **1-800-446-8053 extension 52961** or by sending a written request within 180 days to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Provider Courtesy Review
PO Box 30055
Durham, NC 27702

What if I don't agree with this decision? You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702

A member appeal form is available on the Web at **www.BCBSNC.com**.

What if my situation is urgent? If your situation meets the legal definition of urgency, the review of your claim will be conducted within 72 hours, or earlier if required by law. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your situation is urgent, you or your physician may request an expedited appeal by contacting Blue Cross and Blue Shield of North Carolina (Blue Cross NC) via mail or fax at the address below. In addition, you may have the ability to seek an expedited external review of your adverse benefit determination. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID Card.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level 1
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

Who may file an appeal? You or someone whom you name to act for you (your authorized representative) may file an appeal. A member consent form is attached for your convenience and is also available online at **www.BCBSNC.com**.

Can I provide additional information about my appeal? Yes. As part of the appeal process, you have the right to submit supporting materials in advance of a decision being made on your appeal.

What happens next? If you appeal, BLUE CROSS NC will review the decision and provide you a written determination within 30 calendar days. If the adverse benefit determination is overturned, BLUE CROSS NC will provide coverage or payment for your health care item or service. If the adverse benefit determination is upheld, you may have additional appeal rights.

How do I file a request for external review? You may be eligible for an external review process. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID card.

What other remedies do I have? Depending on your plan, you may also have the right to bring action under section 502(a) of ERISA. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Can I request copies of information relevant to my adverse benefit determination? Yes. You may request and receive, at no cost to you, reasonable access to and copies of all documents, records and other information relevant to your claim by writing to:

Blue Cross and Blue Shield of North Carolina
Healthcare Management & Operations
P. O. Box 2291
Durham, NC 27702

This information may also include the following:

- Any internal rules, guidelines, protocols, or other criteria used to make this decision, including any clinical review criteria indicated above (please include the referenced medical policy from page 1 of this notice with your request); and/or
- If the decision is based on medical necessity, experimental treatment or another similar exclusion, an explanation of the scientific or clinical judgment for the determination, applied to your medical circumstances.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**. You may also receive assistance with appeals from Smart

NC by contacting:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
1-855-408-1212 (toll-free)

External Review
North Carolina law provides for review of *adverse benefit determinations* by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. *BLUE CROSS NC* will notify you of your right to request an external review each time you receive:

- An *adverse benefit determination*, or
- An appeal decision upholding an *adverse benefit determination* or
- A second-level *appeal* decision upholding an *adverse benefit determination.*

You or someone whom you have authorized to represent you may request an external review.

In order for your request to be eligible for an external review, the NCDOI must determine the following:

- Your request is about a *medical necessity* determination that resulted in an *adverse benefit determination (i.e., a noncertification)*;
- You had coverage with *BLUE CROSS NC* when the *adverse benefit determination* was issued;
- The service for which the *adverse benefit determination* was issued appears to be a *covered service*; and
- You have exhausted *BLUE CROSS NC's* internal *appeal* review process as described below.

For a standard external review, you will have exhausted the internal *appeal* review process if you have:

- Completed *BLUE CROSS NC's* first- and second-level *appeal* review and received a written second-level determination from *BLUE CROSS NC*, or
- Filed a second-level *appeal* and have not requested or agreed to a delay in the second-level *appeal* process, but have not received *BLUE CROSS NC's* written decision within 60 days from the date that you can demonstrate that an appeal was filed with BLUE CROSS NC, or
- received written notification that *BLUE CROSS NC* has agreed to waive the requirement to exhaust the internal *appeal* and/or second-level *appeal* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited

review.

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective *adverse benefit determination* (an *adverse benefit determination* that occurs after you have already received the services in question), the 60-day time limit for receiving *BLUE CROSS NC's* second-level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second-level determination from *BLUE CROSS NC*.

Expedited External Review
An expedited external review may be available if the time required to complete either an expedited internal first- or second-level appeal review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- An *adverse benefit determination* from *BLUE CROSS NC* and have filed a request with *BLUE CROSS NC* for an expedited first-level appeal; or
- A first-level appeal decision upholding an *adverse benefit determination* and have filed a request with *BLUE CROSS NC* for an expedited second-level *appeal* review; or
- A second-level *appeal* review decision from *BLUE CROSS NC*.

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first-level appeal or second-level appeal decision concerning an adverse benefit determination of the admission, availability of care, continued stay or emergency health care services.

If your request is not accepted for expedited review, the NCDOI may (1) accept the case for standard external review if you have exhausted the internal appeal review process; or (2) require the completion of the internal appeal review process and another request for an external review. An expedited external review is not available for retrospective adverse benefit determinations.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

(Mail)
By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll-Free Telephone: **1-855-408-1212**
www.ncdoi.com/smart

(In person)
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/Smart
Toll-Free Telephone: **1-855-408-1212**

The Healthcare Review Program provides consumer counseling on utilization review and appeal issues. Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your provider of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BLUE CROSS NC upholding an adverse benefit determination (generally the notice of a second-level appeal review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BLUE CROSS NC has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial adverse benefit determination to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BLUE CROSS NC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BLUE CROSS NC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the adverse benefit determination, appeal decision or the second-level appeal review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BLUE CROSS NC at the same time and by the same means of communication (e.g., you must fax the information to BLUE CROSS NC if you faxed it to the IRO). When sending additional information to BLUE CROSS NC, send it to:

(Mail)
Blue Cross/Blue Shield of North Carolina
Appeals Department
PO Box 30055
Durham, NC 27702

Questions? Do you need help in a different language or format? If you do not speak English or have special needs, oral interpretation and alternate formats of this notice are available, as is other assistance, by contacting us at the number on your State Health Plan ID card.

Spanish:
Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):
如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:
Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:
Shíka at'ohwol ei doodaii' dinék'ehgo łą bi'chį haadeedziih nínízinígo, t'áá shǫǫdí, t'áá jíík'e ya ndaalníshí, ni naaltsoos bikáa'gi bi'chį hodiilniih.

Notice of Nondiscrimination

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
  - Auxiliary aids and services
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator
PO BOX 6590, Lee's Summit, MO 64064-6590
Phone: 1-866-526-4075
TTY: 1-800-863-5488
Fax: 1-855-245-2135
Email: nondiscrimination@cvscaremark.com

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

106-39432A-092316

Exhibit D

CVS caremark

North Carolina State Health Plan

Notice of Determination

Date: 01/17/2020

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B.
Plan Member ID: ******* [redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-9196848225
Prescriber Fax: 1-9198625372

Dear C.B.:

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate IM Injection. The request was denied because:

You do not meet the requirements of your plan. Your Testosterone Products plan covers this drug when you meet one of these conditions:
- You have primary or hypogonadotropic hypogonadism
Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at **888-321-3124**.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

If your situation is urgent as defined by law, you may ask for an expedited appeal. Important information about your appeal rights and directions about how to ask for an

appeal are provided with this letter.

If your provider would like to discuss this decision with a clinical reviewer at CVS Caremark , your provider can call CVS Caremark , and we will make arrangements for the conversation.

If you have questions, please call Customer Care at **888-321-3124**.

Sincerely,

CVS Caremark

Enclosures

cc: Dr. [redacted]

PA# North Carolina State Health Plan 0274 Non-Grandfathered 20-043207569 MN
Plan-approved Criteria: Testosterone Products
Claim Amount (if available):
Service Date: 1/17/2020 12:22:09 PM

If your provider included diagnosis or treatment codes with your claim for Testosterone Cypionate IM Injection to CVS Caremark , that information is listed here:
ICD diagnosis code: F64.0
Associated diagnosis: Transsexualism
CPT treatment code:
Associated treatment:
You may wish to contact your provider for more information about these codes.

Important Information About Your Appeal Rights

What if I need help understanding this denial? You may contact CVS Caremark by calling **1-800-294-5979** if you need assistance understanding this notice or our decision to deny you a service or coverage.

What options does my provider have? If there is relevant information that has not been previously submitted, the treating physician may request a Provider Courtesy Review (PCR) by calling **1-800-446-8053** and ask for Pharmacy Provider Courtesy Reviews or by calling **(919) 765-2961**. You may also send a written request within 180 days to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Provider Courtesy Review
PO Box 30055
Durham, NC 27702

What if I don't agree with this decision? You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702

A member appeal form is available on the Web at **www.BCBSNC.com**.

What if my situation is urgent? If your situation meets the legal definition of urgency, the review of your claim will be conducted within 72 hours, or earlier if required by law. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your situation is urgent, you or your physician may request an expedited appeal by contacting Blue Cross and Blue Shield of North Carolina (Blue Cross NC) via mail or fax at the address below. In addition, you may have the ability to seek an expedited external review of your adverse benefit determination. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID Card.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level 1
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

Who may file an appeal? You or someone whom you name to act for you (your authorized representative) may file an appeal. A member consent form is attached for your convenience and is also available online at **www.BCBSNC.com**.

Can I provide additional information about my appeal? Yes. As part of the appeal process, you have the right to submit supporting materials in advance of a decision being made on your appeal.

What happens next? If you appeal, BLUE CROSS NC will review the decision and provide you a written determination within 30 calendar days. If the adverse benefit determination is overturned, BLUE CROSS NC will provide coverage or payment for your health care item or service. If the adverse benefit determination is upheld, you may have additional appeal rights.

How do I file a request for external review? You may be eligible for an external review process. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID card.

What other remedies do I have? Depending on your plan, you may also have the right to bring action under section 502(a) of ERISA. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Can I request copies of information relevant to my adverse benefit determination? Yes. You may request and receive, at no cost to you, reasonable access to and copies of all documents, records and other information relevant to your claim by writing to:

Blue Cross and Blue Shield of North Carolina
Healthcare Management & Operations
P. O. Box 2291
Durham, NC 27702

This information may also include the following:

- Any internal rules, guidelines, protocols, or other criteria used to make this decision, including any clinical review criteria indicated above (please include the referenced medical policy from page 1 of this notice with your request); and/or
- If the decision is based on medical necessity, experimental treatment or another similar exclusion, an explanation of the scientific or clinical judgment for the determination, applied to your medical circumstances.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.

You may also receive assistance with appeals from Smart NC by contacting:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201**1-855-408-1212** (toll-free)

External Review
North Carolina law provides for review of *adverse benefit determinations* by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. *BLUE CROSS NC* will notify you of your right to request an external review each time you receive:

- An *adverse benefit determination*, or
- An appeal decision upholding an *adverse benefit determination* or
- A second-level *appeal* decision upholding an *adverse benefit determination.*

You or someone whom you have authorized to represent you may request an external review.

In order for your request to be eligible for an external review, the NCDOI must determine the following:

- Your request is about a *medical necessity* determination that resulted in an *adverse benefit determination (i.e., a noncertification)*;
- You had coverage with *BLUE CROSS NC* when the *adverse benefit determination* was issued;
- The service for which the *adverse benefit determination* was issued appears to be a *covered service*; and
- You have exhausted *BLUE CROSS NC's* internal *appeal* review process as described below.

For a standard external review, you will have exhausted the internal *appeal* review process if you have:

- Completed *BLUE CROSS NC's* first- and second-level *appeal* review and received a written second-level determination from *BLUE CROSS NC*, or
- Filed a second-level *appeal* and have not requested or agreed to a delay in the second-level *appeal* process, but have not received *BLUE CROSS NC's* written decision within 60 days from the date that you can demonstrate that an appeal was filed with BLUE CROSS NC, or
- received written notification that *BLUE CROSS NC* has agreed to waive the requirement to exhaust the internal *appeal* and/or second-level *appeal* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective *adverse benefit determination* (an *adverse benefit determination* that occurs after you have already received the services in question), the 60-day time limit for receiving *BLUE CROSS NC's* second-level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second-level determination from *BLUE CROSS NC.*

Expedited External Review
An expedited external review may be available if the time required to complete either an expedited internal first- or second-level appeal review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- An *adverse benefit determination* from *BLUE CROSS NC* and have filed a request with *BLUE CROSS NC* for an expedited first-level appeal; or
- A first-level appeal decision upholding an *adverse benefit determination* and have filed a request with *BLUE CROSS NC* for an expedited second-level *appeal* review; or
- A second-level *appeal* review decision from *BLUE CROSS NC.*

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first-level appeal or second-level appeal decision concerning an adverse benefit determination of the admission, availability of care, continued stay or emergency health care services.

If your request is not accepted for expedited review, the NCDOI may (1) accept the case for standard external review if you have exhausted the internal appeal review process; or (2) require the completion of the internal appeal review process and another request for an external review. An expedited external review is not available for retrospective adverse benefit determinations.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

Questions? Do you need help in a different language or format? If you do not speak English or have special needs, oral interpretation and alternate formats of this notice are available, as is other assistance, by contacting us at the number on your State Health Plan ID card.

Spanish:
Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):
如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:
Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:
Shíka at'ohwol ei doodaii' dinék'ehgo łą bi'chį haadeedziih nínízinígo, t'áá shǫǫdí, t'áá jíík'e ya ndaalníshí, ni naaltsoos bikáa'gi bi'chį hodiilniih.

Exhibit E

CVS caremark

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

Notice of Determination

Date: 03/23/2020

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B.
Plan Member ID: *******[redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-9199543993
Prescriber Fax: 1-9198625782

Dear C.B.

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate 200MG/ML IM SOLN. The request was denied because:

You do not meet the requirements of your plan. Your plan approved Testosterone Products criteria covers this drug when you meet one of these conditions:
- You have primary or hypogonadotropic hypogonadism
- For testosterone enanthate injection (generic Delatestryl), you are a postmenopausal patient with metastatic breast cancer, surgery is not possible, and other drugs for your cancer did not work for you
- For testosterone enanthate injection (generic Delatestryl), you are a premenopausal patient with breast cancer, have a hormone-responsive tumor, and had your ovaries removed
- Testosterone enanthate injection (generic Delatestryl) or Testopel is being prescribed for delayed puberty

Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at **888-321-3124**.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

If your situation is urgent as defined by law, you may ask for an expedited appeal. Important information about your appeal rights and directions about how to ask for an appeal are provided with this letter.

If your provider would like to discuss this decision with a clinical reviewer at CVS Caremark , your provider can call CVS Caremark , and we will make arrangements for the conversation.

If you have questions, please call Customer Care at **888-321-3124**.

Sincerely,

CVS Caremark

Enclosures

cc: Dr. [redacted]

PA# North Carolina State Health Plan 0274 Non-Grandfathered 20-044413290 JR
Plan-approved Criteria: Testosterone Products
Claim Amount (if available):
Service Date: 3/23/2020 3:21:05 PM

If your provider included diagnosis or treatment codes with your claim for Testosterone Cypionate 200MG/ML IM SOLN to CVS Caremark , that information is listed here:
ICD diagnosis code: F64.0
Associated diagnosis: Transsexualism
CPT treatment code:
Associated treatment:
You may wish to contact your provider for more information about these codes.

Important Information About Your Appeal Rights

What if I need help understanding this denial? You may contact CVS Caremark by calling **1-800-294-5979** if you need assistance understanding this notice or our decision to deny you a service or coverage.

What options does my provider have? If there is relevant information that has not been previously submitted, the treating physician may request a Provider Courtesy Review (PCR) by calling **1-800-446-8053** and ask for Pharmacy Provider Courtesy Reviews or by calling **(919) 765-2961**. You may also send a written request within 180 days to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Provider Courtesy Review
PO Box 30055
Durham, NC 27702

What if I don't agree with this decision? You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702

A member appeal form is available on the Web at **www.BCBSNC.com**.

What if my situation is urgent? If your situation meets the legal definition of urgency, the review of your claim will be conducted within 72 hours, or earlier if required by law. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your situation is urgent, you or your physician may request an expedited appeal by contacting Blue Cross and Blue Shield of North Carolina (Blue Cross NC) via mail or fax at the address below. In addition, you may have the ability to seek an expedited external review of your adverse benefit determination. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID Card.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level 1
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

Who may file an appeal? You or someone whom you name to act for you (your authorized representative) may file an appeal. A member consent form is attached for your convenience and is also available online at **www.BCBSNC.com**.

Can I provide additional information about my appeal? Yes. As part of the appeal process, you have the right to submit supporting materials in advance of a decision being made on your appeal.

What happens next? If you appeal, BLUE CROSS NC will review the decision and provide you a written determination within 30 calendar days. If the adverse benefit determination is overturned, BLUE CROSS NC will provide coverage or payment for your health care item or service. If the adverse benefit determination is upheld, you may have additional appeal rights.

How do I file a request for external review? You may be eligible for an external review process. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID card.

What other remedies do I have? Depending on your plan, you may also have the right to bring action under section 502(a) of ERISA. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Can I request copies of information relevant to my adverse benefit determination? Yes. You may request and receive, at no cost to you, reasonable access to and copies of all documents, records and other information relevant to your claim by writing to:

Blue Cross and Blue Shield of North Carolina
Healthcare Management & Operations
P. O. Box 2291
Durham, NC 27702

This information may also include the following:

- Any internal rules, guidelines, protocols, or other criteria used to make this decision, including any clinical review criteria indicated above (please include the referenced medical policy from page 1 of this notice with your request); and/or
- If the decision is based on medical necessity, experimental treatment or another similar exclusion, an explanation of the scientific or clinical judgment for the determination, applied to your medical circumstances.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272).**

You may also receive assistance with appeals from Smart NC by contacting:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-12011-855-408-1212 (toll-free)

External Review
North Carolina law provides for review of *adverse benefit determinations* by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. *BLUE CROSS NC* will notify you of your right to request an external review each time you receive:

- An *adverse benefit determination*, or
- An appeal decision upholding an *adverse benefit determination* or
- A second-level *appeal* decision upholding an *adverse benefit determination.*

You or someone whom you have authorized to represent you may request an external review.

In order for your request to be eligible for an external review, the NCDOI must determine the following:

- Your request is about a *medical necessity* determination that resulted in an *adverse benefit determination (i.e., a noncertification)*;
- You had coverage with *BLUE CROSS NC* when the *adverse benefit determination* was issued;
- The service for which the *adverse benefit determination* was issued appears to be a *covered service*; and
- You have exhausted *BLUE CROSS NC's* internal *appeal* review process as described below.

For a standard external review, you will have exhausted the internal *appeal* review process if you have:

- Completed *BLUE CROSS NC's* first- and second-level *appeal* review and received a written second-level determination from *BLUE CROSS NC*, or
- Filed a second-level *appeal* and have not requested or agreed to a delay in the second-level *appeal* process, but have not received *BLUE CROSS NC's* written decision within 60 days from the date that you can demonstrate that an appeal was filed with BLUE CROSS NC, or
- received written notification that *BLUE CROSS NC* has agreed to waive the requirement to exhaust the internal *appeal* and/or second-level *appeal* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective *adverse benefit determination* (an *adverse benefit determination* that occurs after you have already received the services in question), the 60-day time limit for receiving *BLUE CROSS NC's* second-level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second-level determination from *BLUE CROSS NC*.

Expedited External Review
An expedited external review may be available if the time required to complete either an expedited internal first- or second-level appeal review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- An *adverse benefit determination* from *BLUE CROSS NC* and have filed a request with *BLUE CROSS NC* for an expedited first-level appeal; or
- A first-level appeal decision upholding an *adverse benefit determination* and have filed a request with *BLUE CROSS NC* for an expedited second-level *appeal* review; or
- A second-level *appeal* review decision from *BLUE CROSS NC.*

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first-level appeal or second-level appeal decision concerning an adverse benefit determination of the admission, availability of care, continued stay or emergency health care services.

If your request is not accepted for expedited review, the NCDOI may (1) accept the case for standard external review if you have exhausted the internal appeal review process; or (2) require the completion of the internal appeal review process and another request for an external review. An expedited external review is not available for retrospective adverse benefit determinations.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

(Mail)
By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll-Free Telephone: **1-855-408-1212**
www.ncdoi.com/smart

(In person)
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/Smart
Toll-Free Telephone: **1-855-408-1212**

The Healthcare Review Program provides consumer counseling on utilization review and appeal issues. Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your provider of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BLUE CROSS NC upholding an adverse benefit determination (generally the notice of a second-level appeal review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BLUE CROSS NC has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial adverse benefit determination to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BLUE CROSS NC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BLUE CROSS NC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the adverse benefit determination, appeal decision or the second-level appeal review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BLUE CROSS NC at the same time and by the same means of communication (e.g., you must fax the information to BLUE CROSS NC if you faxed it to the IRO). When sending additional information to BLUE CROSS NC, send it to:

(Mail)
Blue Cross/Blue Shield of North Carolina
Appeals Department
PO Box 30055
Durham, NC 27702

Questions? Do you need help in a different language or format? If you do not speak English or have special needs, oral interpretation and alternate formats of this notice are available, as is other assistance, by contacting us at the number on your State Health Plan ID card.

Spanish:
Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):
如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:
Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:
Shíka at'ohwol ei doodaii' dinék'ehgo łą bi'chį haadeedziih nínízinígo, t'áá shǫǫdí, t'áá jíík'e ya ndaalníshí, ni naaltsoos bikáa'gi bi'chį hodiilniih.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark .
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-40230B 081319 TDD/TTY: 1-800-863-5488